THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

GUIDANCE TO STATES ON THE LOW-INCOME SUBSIDY

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Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries. The new program goes into effect January 1, 2006. The MMA also provides extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls. The subsidy provides assistance with the premium, deductible and co-payments of the program. Beneficiaries may apply for the Low-Income Subsidy (LIS) with the Social Security Administration (SSA) starting in May 2005 or with their State Medicaid agency starting in July 2005.

Medicare beneficiaries who wish to enroll in the Medicare Prescription Drug Program must choose a prescription drug plan through which to receive the benefit. There is an initial open enrollment period from November 15, 2005 through May 15, 2006, during which beneficiaries can enroll in a plan. There will be subsequent enrollment periods for the Medicare Prescription Drug Program each year.

Generally, coverage for the drug benefit will be provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare health plans that offer both prescription drug and health care coverage (known as MA-PDs). Both types of plans must offer a standard drug benefit, but will have the flexibility to vary the drug benefit. Covered Part D drugs are essentially the same drugs and biologicals that are approved for the Medicaid program (although selection may be restricted through a plan's formulary) and they must be dispensed by prescription and on an outpatient basis. Drugs and biological products that are paid for by Medicare Part A or B are excluded.

The new law requires both Social Security and the States to accept and process applications for the low-income subsidy (LIS). The law also requires States to screen subsidy applicants who apply at the State Medicaid office for eligibility for the Medicare Saving Programs (Qualified Medicare Beneficiary [QMB], Specified Low-Income Medicare Beneficiary [SLMB], and Qualified Individual [QI]). This guidance provides States with information about making the subsidy determination and how to expedite determinations for the subsidy and for the Medicare Saving Programs (MSP) determinations. Federal financial participation (FFP) is available for these activities.

This Guidance is intended for use by States in processing SSA applications and making determinations for subsidy eligibility upon request. It will be updated periodically to reflect changes as necessary.

10 Applying for the Subsidy

10.1 Who Must Apply

Beneficiaries with limited income and resources who do not fall into one of the deemed subsidy groups must apply for the low-income subsidy. Their eligibility for subsidy assistance can be determined by either the Social Security Administration (SSA) or their State Medicaid office.

For beneficiaries who apply for the subsidy, the type of income to be counted will be based on the rules of the Supplemental Security Income (SSI) program (see 20 CFR § 416 Subparts K and L). Generally the income of the applicant and that of his/her spouse who resides with the applicant will be counted. (Also see the SSA Program Operations Manual System [POMS], available at http://policy.ssa.gov/poms.nsf/aboutpoms, for additional guidance.) Once counted, income will be compared to the federal poverty level standard applicable to the size of the applicant's family to determine eligibility. (See the Federal Poverty Level tables in Appendices V, VI and VIII.) Family size includes the applicant, the spouse residing with the applicant, if any, and the number of individuals who are related to the applicant or spouse, who are living in the applicant's household, and who depend on the applicant or spouse for at least one half of their financial support.

Resources (assets) are considered in determining eligibility for a subsidy. Resources that will be considered in determining eligibility generally include liquid resources that can be readily converted to cash within 20 days (e.g., checking and savings accounts). Also countable is real property that is not the applicant's primary residence and not attached to the primary residence. The resources of the applicant and their spouse, if any, will be counted to determine if the applicant meets the resource threshold to be eligible for a Part D low-income subsidy. Resources of dependent family members are not counted for the applicant and their spouse. If dependent family members are Medicare beneficiaries themselves, they must file their own subsidy application or be deemed eligible in their own right.

10.2 Who Doesn't Have to Apply (Deemed Eligibles)

Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy and do not have to apply. These groups are deemed eligible for the subsidy for calendar year 2006. The following groups are deemed eligible:

- Full-benefit dual eligibles (FBDEs) who are persons eligible for both Medicare and full Medicaid benefits.
- Supplemental Security Income (SSI) recipients, including SSI recipients who receive a cash benefit but not Medicaid.
- Medicare beneficiaries who are participants in the Medicare Saving Programs (MSP), which are QMB, SLMB, and QI.

Deemed eligibles do not need to file an application for the subsidy. CMS will automatically award them the subsidy based on information received from the States and SSA and notify them that they are eligible without having to file an application. They do, however, need to choose a prescription drug plan. Full-benefit dual eligibles who fail to choose a plan by December 31, 2005, will be enrolled by CMS in a plan, effective January 1, 2006. As CMS is specifying in further guidance, QMBs, SLMBs, QIs, SSI recipients, and others who apply and are found

eligible for the subsidy, will be enrolled in a plan in May 2006, with coverage effective June 1, 2006, if they do not choose a plan on their own.

Individuals who attain age 65 or reach their 25th month of receipt of disability benefits and become eligible for Medicare after January 1, 2006 will undergo the same actions to determine their eligibility for the subsidy. These individuals, known as **attainers**, will be processed monthly. CMS will determine if these individuals can be deemed eligible for the subsidy, based on information received from the States and SSA, and notify the beneficiaries that they need not apply. If deeming is not applicable, these individuals may apply for the subsidy.

10.3 How to Apply

Individuals who are not deemed eligible may apply by contacting:

- SSA (by mail, by telephone, on the Internet at www.ssa.gov, or in person.)
- Their State Medicaid agency.

10.3.1 The SSA Application

A simplified application form and process for determination and verification of an eligible beneficiary's income and resources (assets) for purposes of the Medicare Prescription Drug benefit has been developed by SSA and will be available for on-line, mail, in-person, and phone filing. The application form consists of an attestation regarding a beneficiary's income, family size, and assets. This means that beneficiaries will not have to gather together and bring volumes of files to a government office. Regardless of the manner in which an individual files the SSA application, no financial documents will be necessary at the time of application. SSA will verify most information through data matches with existing SSA, Internal Revenue Service and other government files. SSA may need to request some follow-up documentation to resolve discrepancies between data matches and attestations in the application. Individuals will also be contacted if they own property other than their primary residence and the land it is on or if they leave questions on the application unanswered.

States will receive guidance from SSA (see State MMA Program Orientation which will be available to States on compact disc and on the SSA website [www.ssa.gov] under "Medicare Outreach") on the completion of the SSA scannable application.

10.3.2 Using the SSA-1020

If the Medicare beneficiary is amenable to using the SSA-1020, the State may assist him/her in completion of the form. (See State MMA Program Orientation). Because the SSA-1020 is an electronically scannable document, the State should observe the following:

- **NO PHOTOCOPIES** – Do not photocopy the SSA-1020 to increase the State's supply of the form. Photocopying makes the form unscannable and could adversely impact the

timeliness of an SSA decision regarding the low-income subsidy. The State may obtain additional supplies of the SSA-1020 from its SSA Regional Communications Director.

- **NO DATE STAMPS** – Date stamps interfere with the scannability of the form. Enter a hand-written date in the "For Official Use Only" box on page 2, showing the date the form is completed.

Submit completed SSA-1020s to the Wilkes-Barre Data Operations Center (WBDOC) using the pre-addressed, pre-paid envelope provided with the form. If the envelope is missing, mail the form to:

Social Security Administration
Wilkes-Barre Data Operations Center
P. O. Box 1020
Wilkes-Barre, PA 18767-9910

IMPORTANT: All subsidy applications taken on the SSA application (SSA-1020) become the responsibility of SSA for the eligibility determination and all subsequent case activity (i.e., notices, appeals, redeterminations).

10.3.3 The State Application

States are strongly encouraged to use the Social Security Administration's subsidy application (SSA-1020) for subsidy applicants unless an individual specifically requests that the State make the subsidy determination using a State application form. States should ask applicants if they have already applied for the subsidy with SSA and, if so, urge them to wait for a decision from SSA. However, if the applicant insists on filing with the State prior to an SSA decision, the State must comply. If an individual requests a State determination or refuses to use the SSA application, the State must use its own application and process the case using Federal Low-Income Subsidy income, family size, and resource rules, but the State's process for taking applications. The State is then responsible for notices, appeals, and redeterminations for subsidy cases it has determined using a State application form.

The State may use any existing application form which captures:

- Income of applicant and spouse, if any (which may not exceed 150% of the Federal Poverty Level);
- Family size (which includes the applicant, their spouse if living with them, and financially dependent relatives who live with them); and
- Resources of applicant and spouse, if any (which may not exceed $11,500* for one person and $23,000* for a couple).

* These amounts apply if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, the resource standards are $10,000 for one person and $20,000 for a couple.

The State may also modify an existing application to capture this data. For example, if the State has a QMB/SLMB/QI application that captures income and resource data for the applicant and spouse, such an application would only require an addendum for family size to meet the requirements of the subsidy application. Since States are required under 1935 (a)(3) of the Social Security Act and 42 CFR § 423.904 (c) to screen subsidy applicants for QMB/SLMB/QI eligibility, this single application could serve both purposes.

10.3.4 Responsibility for LIS Applications

Application Site	Agency Responsible for the Case
SSA	SSA
State, using SSA application	SSA
State, using State application	State
Deemed-No Application	CMS (based on State data)

20 Coordinating LIS and MSP Applications

As described in 10.3.3, the State may modify its MSP application for the LIS process. States are strongly encouraged to conduct the LIS and MSP application processes simultaneously to minimize delays in the applicant's receipt of benefits. If the evidence at the time of application indicates that the applicant would qualify for the subsidy, the subsidy application should be processed immediately. If the beneficiary later qualifies for MSP, s/he will be deemed eligible for the subsidy. On the other hand, if the evidence indicates that the applicant would qualify for MSP but not qualify for LIS, the MSP application should be processed immediately, since the individual would be deemed eligible for the subsidy and need not apply.

States must use Federal rules for the subsidy determination, and the State's rules for the MSP determination. If, based on the State's rules, a subsidy applicant is found eligible for QMB/SLMB/QI (MSP) they become deemed eligible for the subsidy, even if they would have not qualified otherwise. If a subsidy applicant is found eligible for SLMB/QI (MSP) and thus deemed eligible for the subsidy, the State can close its LIS screening. (QMB cases will require additional LIS screening.) CMS currently assumes responsibility for the subsidy cases of the deemed eligibles. States will have on-going responsibility (notices, appeals, redeterminations) for the MSP case.

20.1 Screening LIS Applicants for MSP (QMB/SLMB/QI) Eligibility

States are required to screen individuals applying at state offices for the Medicare Part D Low-Income Subsidy (LIS) for possible Medicare Savings Program (MSP) eligibility, and offer those individuals the opportunity to enroll in an MSP. We view our discussion in the preamble to our Final Rule (published in the Federal Register on January 28, 2005) to require states to screen and

offer enrollment to LIS applicants regardless of whether the state itself is making the LIS eligibility determination, or just assisting the applicant in completing a LIS application which will be submitted to SSA for a determination of LIS eligibility by that agency. In any instance where a state has contact with an applicant for LIS, the state must screen for MSP eligibility and offer to enroll the applicant in its Medicare Savings Program.

If people apply for LIS directly with SSA, rather than with or through a state office, states are not required to screen for and offer MSP enrollment to those individuals. However, CMS is strongly encouraging states to do so, even though the state may not have direct initial contact with these applicants.

To assist states in this effort, SSA has offered to make available to states, through CMS, information about those individuals who apply for LIS directly with SSA. This information, known as leads data, can assist the states in identifying beneficiaries who may qualify for a Medicare Saving Program. The data elements found in leads data are listed in Appendix VIII.

For the MSP determination, the State's usual rules apply to all parts of the application process including who may represent the applicant, the interview (if any), screening and clearances, technical requirements, unit size, notices and appeal rights, appeals and fair hearings, and redeterminations. The State's rules also apply to financial criteria and may include any rules adopted under Section 1902 (r) (2).

20.1.1 Federal Medicare Saving Programs' Parameters

- Maximum Resources: $4,000 (individual)/ $6,000 (couple).
- Maximum Income: 135% of the Federal Poverty Level.

20.1.2 Voluntary Enrollment

If the applicant is found eligible for MSP, s/he must be offered enrollment, which s/he is free to decline.

- If the applicant accepts enrollment, s/he becomes deemed eligible for the LIS. If the applicant is eligible for SLMB or QI, the State can close its LIS application. If the applicant qualifies for QMB, the State must continue the LIS application process to determine subsidy eligibility for months prior to QMB eligibility. (LIS eligibility begins as of the first day of the month of application. SLMB/QI eligibility can begin up to three months prior to the month of application. QMB eligibility begins effective the first day of the month following the month in which eligibility is determined.)

- If the applicant has applied for the LIS using the State application and he or she declines MSP enrollment, the State must continue screening the applicant for eligibility for the Low-Income Subsidy.

30 Determining Subsidy Eligibility

In the event that an applicant requests a State LIS determination using a State application, the State must comply. Unless the applicant is later found to be deemed eligible for the subsidy or has been found eligible for the LIS by SSA, the State will also be responsible for ongoing case activity, including notices, appeals, and redeterminations, consistent with scenarios described in Appendix IV.

30.1 The Applicant's Representative

The applicant may be represented by any of the following individuals:

- An individual who is authorized to act on behalf of the applicant;
- If the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf;
- An individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process;
- Anyone may help the individual apply for the subsidy.

The person assisting the applicant is required to attest to the accuracy of the information on the application.

30.2 Interview

A face-to-face interview is not required for the LIS process, but may be conducted at the State's option.

30.3 Screening for Deemed Eligibility

The State must conduct its usual screening process to determine if the applicant is eligible for Medicaid, SSI or one of the Medicare Saving Programs (QMB, SLMB, QI). If the applicant is found to be currently enrolled in one of these programs, dispose of the LIS application, as the applicant is deemed eligible for the subsidy and no application is required.

30.4 Clearances

States should conduct their usual SDX/SVES/SOLQ clearances to verify the applicant's entitlement/enrollment in Medicare Parts A and B. If no Medicare entitlement/enrollment can be confirmed, deny the LIS application. If the available data confirm Medicare Buy-In in another U.S. jurisdiction, the applicant is deemed eligible for the subsidy and the State's determination of subsidy eligibility should be disposed of. The new State of residence should inform the prior State of residence of the change of address, and offer an MSP application to the beneficiary, explaining that if s/he qualifies for MSP in the new State of residence, s/he automatically qualifies for LIS.

30.4.1 Eligibility for Part D (Technical Requirements)

To qualify for Medicare Part D, the beneficiary must:

- Be entitled to Medicare Part A and/or enrolled in Medicare Part B; and
- Must reside in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

30.5 Spenddown

If the applicant is pending Medicaid spenddown in the month of application for the subsidy, continue with the LIS determination, using gross income prior to spenddown. If the applicant meets Medicaid eligibility during the month of subsidy application, s/he is deemed eligible for the LIS and the State should dispose of the LIS application. Once deemed, the beneficiary will receive the subsidy for the remainder of the calendar year (in 2006).

30.6 Family Size

For the purpose of establishing the applicable income standard only, the following persons will be counted in the family size:

- The applicant;
- The applicant's spouse, if living with the applicant; and
- Any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.

The applicant's income tax records may be useful for determining who has been considered a dependent relative in the past. However, be aware that IRS does not require the dependent family member to live with the applicant while the subsidy family size criteria does.

30.7 Financial Requirements

Modified Supplemental Security Income (SSI) regulations (20 CFR § 416 Subparts K and L) are used to evaluate income and resources for subsidy eligibility. The following summary of income and resource information is for reference only. To ensure accuracy and timeliness, this information should be compared to SSI policy frequently. The most current SSI policy can be found in the on-line Program Operations Manual System (POMS) at http://policy.ssa.gov/poms.nsf/aboutpoms.

The intent of the MMA was that the State and SSA determinations would be identical given the same information about the applicant/spouse. Therefore, less restrictive rules the State uses for Medicaid and MSP, including rules adopted under Section 1902 (r)(2), cannot be used for the LIS determination. If the State's computer system is programmed for Medicaid and MSP rules, it is appropriate to perform the Low-Income Subsidy computation off-line.

30.8 Evaluating Resources:

Resources of the applicant and their spouse if living with them but not resources of dependent family members will be considered.

Count liquid resources which are:

- Cash; and
- Other resources which can be converted to cash within 20 days, including, but not limited to:
    - Stocks;
    - Bonds;
    - Mutual fund shares;
    - Promissory notes;
    - Mortgages;
    - Whole life insurance policies;
    - Financial institution accounts, including:
        - Savings;
        - Checking; and
        - Time deposits, also known as certificates of deposit;
        - Individual Retirement Accounts (IRAs);
        - 401 (K) accounts;
        - And similar items;
    - Real property not contiguous with home property.

30.8.1 Resource Standards

The maximum subsidy resource standards are $10,000 for one person and $20,000 for a couple. Resources at or below $6,000 for an individual and $9,000 for a couple and income at or below 135% of the Federal Poverty Level will entitle the applicant(s) to the full subsidy. The SSA subsidy application (SSA-1020) lists $11,500 for an individual and $23,000 for a couple to reflect the burial fund exclusion for one person and a couple. These amounts apply only if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, the resource standards are $10,000 for one person and $20,000 for a couple.

30.8.2 Resource Exclusions

The following resources are not to be considered for purposes of determining LIS eligibility:

- The applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and their spouse have an ownership interest and which serves as his or her principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings;

- Non-liquid resources, other than real property. These include, but are not limited to:

    - Household goods and personal effects;

  - Automobiles, trucks, tractors and other vehicles;
  - Machinery and livestock;
  - Noncash business property;

- Property of a trade or business which is essential to the applicant/spouse's means of self-support;

- Nonbusiness property which is essential to the applicant/spouse's means of self-support;

- Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

- Whole life insurance owned by an individual (and spouse, if any) if the total face value of all the life insurance policies on any person does not exceed $1,500. When the total face value of all policies exceeds $1,500, the cash surrender value of all policies is countable;

- Term life insurance that has no cash surrender value;

- Restricted, allotted Indian lands, if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal government;

- Payments or benefits provided under a Federal statute other than title XVI of the Act where exclusion is required by such statute;

- Federal disaster relief assistance received on account of a Presidentially declared major disaster, including accumulated interest, or comparable State or local assistance;

- Funds of $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse;

- Burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the grave site, and other customary and traditional repositories for the deceased's bodily remains, for the applicant/spouse;

- Retained retroactive SSI or Social Security benefits for nine months after the month they are received;

- Certain housing assistance;

- Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received;

- Payments received as compensation incurred or losses suffered as a result of a crime (Victims' compensation payments), for nine months beginning with the month following the month of receipt;

- Relocation assistance from a State or local government, for nine months, beginning with the month following the month of receipt;

- Dedicated financial institution accounts consisting of past-due benefits for an SSI-eligible individual under age 18;

- A gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501 (a) of such Code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed $2,000; and

- Funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical and/or social services.

30.8.3 Determining Countable Resources

30.8.3.1 General Rule
Countable resources are determined as of the first moment of the month of application or redetermination for the subsidy.

30.8.3.2 Equity Value
Resources, other than cash, are evaluated according to the applicant/spouse's equity in the resources. The equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area involved. Encumbrances include liens, mortgages, and other obligations against the value of the resource. Count the equity value of real property that is not contiguous with home property. There are other rules that apply in calculating the value of resources. See the SSA POMS at http://policy.ssa.gov/poms.nsf/aboutpoms for additional information.

30.8.3.3 Relationship of Income to Resources
Cash received by the applicant or his/her spouse during a month is evaluated under the rules for counting income during the month of receipt. If he or she retains the cash until the first moment of the following month, the cash is countable as a resource unless it is otherwise excludable.

30.8.4 Funds Held in Financial Institution Accounts

30.8.4.1 Owner of the Account
Funds held in a financial institution account (including savings, checking, and time deposits also known as certificates of deposit) are considered the applicant/spouse's resources if he or she owns the account and can use the funds for his or her support and maintenance.

30.8.4.2 Individually-held Account
If the applicant/spouse is designated as the sole owner by the account title and can withdraw and use funds from that account for his or her support and maintenance, all of the account's funds are the applicant/spouse's resource regardless of the source. For as long as these conditions are met, the State will presume that the applicant/spouse owns 100 percent of the funds in the account. This presumption is not rebuttable.

30.8.4.3 Jointly-held Account
If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, the State will presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, the State will presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this paragraph, he or she may rebut the presumption. Rebuttal is a procedure which permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to him or her.

30.9 Evaluating Income

30.9.1 Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet his/her needs for food or shelter. The gross income of the applicant and his/her spouse if living with him or her, but not dependent family members, will be considered. However, dependent family members will be counted in the family size.

30.9.2 Earned income consists of the following types of payments:
- Wages;
- Net earnings from self-employment;
- Payments for services performed in a sheltered workshop or work activities center; and
- Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered.

30.9.2.1Wages is counted at the earliest of the following points:
- When received;
- When credited to the person employed; or
- When set aside for the employee's use.

Net earnings from self-employment are counted on a taxable year basis. Net losses, if any, are deducted from other earned income, but not from unearned income.

Payments for services performed in a sheltered workshop or work activities center are counted when received or set aside for the employee's use.

30.9.2.2 In-kind earned income is counted based on current market value. If the applicant/spouse receives an item that is not fully paid for and he or she is responsible for the balance, only the paid up value is income to the applicant.

30.9.2.3 Honoraria for services rendered and royalty payments that you receive in connection with any publication of your work count as earned income.

30.9.2.4 Period under Consideration
The period for which earned income is counted is, in 2006, the remainder of the calendar year, starting with the month of application for the subsidy. Adjust prospective earned income based on the number of months remaining in the calendar year. The income standard against which the income is measured should be adjusted to reflect the same number of months.

For subsidy applications filed in 2005, eligibility cannot begin prior to January 1, 2006.

30.9.2.5 Earned Income Exclusions
Apply exclusions in the order listed below:

- Refund of Federal income taxes and payments under the Earned Income Tax Credit;
- The first $30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;
- Any portion of the $20 per month exclusion that has not been excluded from combined unearned income;
- $65 per month of the applicant/spouse's earned income;
- For applicants who are under age 65 and receive a Social Security Disability Insurance benefit based on disability, 16.3% of gross earnings for impairment related work expenses (IRWE).
- One half of the applicant/spouse's remaining earned income; and
- For applicants who are under age 65 and receive a Social Security Disability Insurance benefit that is based on blindness, 25% of gross earnings for blind work expenses (BWE).

30.9.3 Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points:

- when received;
- when credited to the recipient; or
- when set aside for the recipient's use.

Unearned income includes, but is not limited to:

- Social Security;
- Railroad Retirement;
- Veterans benefits;
- Temporary Assistance for Needy Families (TANF);
- Pensions;
- Annuities;
- Alimony and support payments;

- Rents;
- Workmen's Compensation;
- In-kind support and maintenance;
- Death benefits;
- Royalties not counted as earned income; and
- Dividends and interest not otherwise excluded under SSI rules.

30.9.3.1 Adjustments to Unearned Income

30.9.3.1.1 In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly Supplemental Security Income (SSI) benefit rate for an individual or a couple, if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

Example 1: Mr. and Mrs. Maple live rent-free in a home that belongs to their son. The house would otherwise rent for $900 per month. **In 2005, one third of the SSI benefit for a couple is $286.77.** Therefore, the Maples receive in-kind support valued at $ 286.77 per month.

Example 2: Mr. Oak cannot manage his housing expenses on his income alone. His daughter helps him by paying his electric bill which averages $150 per month. **In 2005, one third of the SSI benefit for one person is $193.** Therefore, Mr. Oak receives in-kind support valued at $150 per month.

30.9.3.1.2 When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

Example: Mr. Poplar failed to pay income taxes and his Social Security check has been garnished to pay IRS. The gross amount of his benefit is $1,150 per month; he actually receives $750. The gross amount ($1,150) is countable.

30.9.3.1.3 If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, or damages, such as medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

30.9.3.1.4 Subtract from veterans benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the Department of Veteran Affairs.

30.9.3.1.5 Subtract from death benefits the expenses of the deceased person's last illness and death paid by the recipient.

30.9.3.2 Unearned Income Exclusions
The following types of unearned income are not considered for purposes of determining LIS eligibility:

- Supplemental Security Income (SSI) benefits;
- Any public agency's refund of taxes on real property or food;
- Need-based assistance wholly funded by a State or one of its subdivisions, including State supplementation of SSI benefits but not a Federal/State grant program such as TANF;
- Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses. Any portion set aside or used for food, clothing or shelter is countable;
- Food which the applicant or their spouse raise if it is consumed by them or their household;
- Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster;
- Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;
- Payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;
- Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;
- Home energy assistance (any assistance related to meeting the costs of heating or cooling a home);
- One-third of support payments made to or for the applicant by an absent parent if the applicant is a child;
- The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;
- Housing assistance-any assistance paid with respect to a dwelling unit under:

  - The United States Housing Act of 1937;
  - The National Housing Act;
  - Section 101 of the Housing and Urban Development Act of 1965;
  - Title V of the Housing Act of 1949; or
  - Section 202(h) of the Housing Act of 1959;

- Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;

- Gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;

- Payments made to the applicant or their spouse from a fund established by the State to aid victims of crime;

- Relocation assistance provided to the applicant or their spouse by the State or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

- Hostile fire pay received from one of the uniformed services;

- The first $60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or

- Any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a Federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004 (see POMS SI 01130.050).

40 Verifications for the Low-Income Subsidy

When the beneficiary uses the State application, the State may require submission of statements from financial institutions for the application to be considered complete. In addition, the State may require that information on the application be verified in a manner the State determines to be most cost-effective and efficient. States will not have access to the data bases used by SSA and will not have access to the information SSA gathers.

50 Calculating Low-Income Subsidy Eligibility

- Using the family size reported by the applicant and their countable net income, determine where the applicant and their spouse, if any, fall on the appropriate poverty level table (See Appendices V, VI and VII).

- Using the percent of the Federal Poverty Level (FPL) and the applicant/spouse's countable resources, find the subsidy code (A through F) on the subsidy calculation table for one person or a couple (See Appendix II).

- Using the subsidy code, identify the applicable benefits on the subsidy benefits table.

- The SSA Calculator Tool may be used for this calculation. This resource may be found at www.ssa.gov under "Medicare Outreach".

Example:
Mr. and Mrs. Spruce are Medicare beneficiaries who live in Pennsylvania. They are raising their 15-year-old grandson. Their countable net income is $1,500 per month. They have $18,000 in countable resources.

- Find their income range on the Family Size-3 line of the Poverty Level Guidelines in Appendix V. The Guidelines show that their income falls below 135% of the FPL.

- Using the percent of FPL and the total countable resources, find the subsidy code on the subsidy calculation table for Couples (Appendix II). The correct answer is "B".

- Transpose the percentage of premium level for "B" onto the Spruces' approval notice.

60 Notices

If a State application is used, the State must provide the following:

60.1 Approval Notice
If the State determined an individual eligible for LIS, it is required to send an approval notice containing the following required data:
- Application date;
- Regulatory basis for the decision, if required by the State;
- Description of how the subsidy was calculated; what income, family size, and resources were used;
- Premium percentage;
- Effective date of eligibility;
- Who made the decision and how to contact them;
- Appeal rights and procedures; and
- **Reminder to apply for a prescription drug plan**.

60.2 Denial Notice
If the State determines an individual ineligible for LIS, it is required to send a denial notice containing the following required data:
- Application date;
- Reason for denial;
    - Not Medicare-eligible;
    - Failure to complete the application process;
    - Income exceeds 150% FPL;
    - Resources exceed $11,500/$23,000 (see note in 10.3.3);
    - Not a resident of the State;
    - Not a resident of U.S./incarcerated.

- Regulatory basis for decision, if required by the State;
- Description of how the denial was calculated; what income, family size, and resources were used;
- Who made the decision and how to contact them;
- Appeal rights and procedures; and
- **Depending on the denial reason, a reminder to apply for a prescription drug plan**.

60.3 Termination Notice
If the State determines an individual no longer eligible for LIS, it is required to send a termination notice containing the following required data:

- Reason for termination;
    - Not Medicare-eligible;
    - Failure to complete the redetermination process;
    - Income exceeds 150% FPL;
    - Resources exceed $11,500/$23,000 (see note in 10.3.3);
    - Not a resident of the State;
    - Not a resident of U.S./incarcerated.
- Regulatory basis for termination, if required by the State;
- Description of how the termination was calculated; what income, family size, and resources were used;
- Effective date of termination;
- Who made the decision and how to contact them:
- Appeal rights and procedures; and
- **Depending on the termination reason, a reminder that they will still use their prescription drug plan**.

60.4 Change Notice
If the State determines an individual's eligibility for LIS has changed, it is required to send a change notice containing the following required data:

- Reason in change in subsidy level;
- Regulatory basis for change, if required by the State;
- New premium percentage;
- Description of how the change was calculated; what income, family size, and resources were used;
- Effective date of change;
- Who made the decision and how to contact them;
- Appeal rights and procedures; and
- **Reminder that they will still use their prescription drug plan but that their costs within the plan have changed**.

All notices must meet the adequate and timely notice requirements of the State's Medicaid State Plan.

Note: Model notices will be provided by CMS at a later date.

70 Appeals and Fair Hearings

The subsidy applicant may appeal his/her Low-Income Subsidy determination, made using the State application, according to the appeal procedures found in the State's Medicaid State Plan. SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

80 Periods of Eligibility

If a beneficiary is eligible for the Low-Income Subsidy based on a State application, the effective period of eligibility is as follows:

80.1 For calendar year 2006-Initial eligibility determinations are effective as of the first day of the month of application, but not earlier than January 1, 2006, and remain in effect for a period not to exceed one year.

80.2 For any calendar year after 2006-Initial eligibility determinations are effective as of the first day of the month of application and remain in effect for a period consistent with the State plan, but not to exceed one year. Redeterminations must be made in the same manner and frequency as redeterminations are made under the State plan.

80.3 Retroactive eligibility The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.

Example: Ms. Gingko files a subsidy application in August 2005. If she qualifies, her subsidy will be effective January 1, 2006.

Example: Mr. Dogwood files a subsidy application in March 2006. If he qualifies, his subsidy will be effective March 1, 2006.

90 Interim Changes (Subsidy-Changing Events)

States may require beneficiaries receiving the subsidy to report changes in their circumstances within 10 working days of the change. Changes in the beneficiary's circumstances can affect their eligibility for the subsidy or change the level of the subsidy. The State would react to a report of a change as it would under the State's Medicaid plan.

Beneficiaries who become eligible for Medicaid, SSI, QMB, SLMB, and QI after being found eligible for the subsidy join the deemed population. The State can then close its on-going subsidy case for the beneficiary while maintaining the Medicaid or MSP case. CMS will notify the beneficiary that s/he is now deemed. CMS will also redetermine subsidy eligibility of the deemed eligibles on a yearly basis to maintain their subsidy eligibility. If a beneficiary subsequently loses deemed status, CMS will notify him/her of the need to apply at SSA or his/her State Medicaid agency so that s/he can retain eligibility for the low-income subsidy.

100 Redetermination

States are required to redetermine subsidy eligibility in the same manner and frequency as redeterminations are required under the State's Medicaid Plan.

110 Multiple Determinations for the Same Applicant

The State may not know if a subsidy application has also been filed at SSA. However, CMS is working with States and SSA to facilitate information sharing so that CMS will know whether an individual has been found eligible by SSA or a State.

In the case of multiple determinations based on applications in different months, the later application is void if the individual has received a positive subsidy determination on the earlier application with the State or SSA (see 42 CFR§ 423.774). This is so even if the earlier decision is a partial subsidy and the later decision is a full subsidy. If two approvals occur in the same month, the SSA decision takes precedence, even if it provides a lower level of subsidy. All decisions may be appealed, including denials, effective dates, and partial subsidies, with the agency that is responsible for the decision. (See Appendix IV-Precedence of LIS Decisions.)

APPENDIX I

Q. Who qualifies for Medicare Prescription Drug Coverage?

A. An individual is eligible for Medicare Prescription Drug Coverage if he or she:

- Is entitled to Medicare Part A and/or enrolled in Medicare Part B, and
- Lives in the service area of a prescription drug plan (PDP) or Medicare Health Plan with Prescription Drug Coverage (MA-PD) (Service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia and U.S. Territories.)

Q. How is Medicare Prescription Drug Coverage funded?

A. Medicare Prescription Drug Coverage is a Medicare benefit and, unlike Medicaid, is funded entirely with Federal dollars. There are no State funds involved.

Q. What is the Standard Coverage (without extra help)?

A. Beginning in 2006, Medicare beneficiaries will have access to the standard drug coverage described below. Although drug plan sponsors may change some of the specifications below, the coverage offered must at least be equal in value to the standard coverage. Standard coverage includes:

- A monthly premium of about $37
- A yearly deductible of $250
- Co-payment of 25 percent up to an initial coverage limit of $2250
- Protection against high out-of-pocket prescription drug costs, with co-pays of generally $2 for generics and preferred drugs and $5 for all other drugs, or 5 percent of the price, once the enrollee's yearly out-of-pocket spending reaches $3,600.

Q. What is the Extra Help with drug plan costs?

A. The extra help is financial assistance with the monthly premium, the yearly deductible, the per-prescription co-payment, and continuous coverage with no gap prior to reaching $3,600 in out-of-pocket spending. The help may be full or partial depending on the income, family size and resources of the beneficiary.

Q. What is the Full Extra Help?

A. Beneficiaries with very low savings and incomes will receive:

- A $0 yearly deductible
- A $0 monthly premium if their drug plan's premium does not exceed the LIS premium subsidy amount
- Continuous coverage prior to catastrophic coverage.
- Co-pays of not more than $2 for generics and preferred drugs and not more than $5 for other drugs up to the out-of-pocket limit.
- No co-pays for prescriptions after reaching $3,600 in out-of-pocket spending.

Beneficiaries with Medicare and Medicaid and income at or below 100% of the FPL will have co-pays reduced to $1 and $3, respectively, up to the out-of-pocket limit. Beneficiaries who have full Medicaid benefits and reside in an institution will have no co-payments.

Q. What is the Partial Extra Help?
A. Beneficiaries with limited savings and income below 150% of the federal poverty level can enroll in a plan with:

- A sliding scale monthly premium that is between $0 and about $37.
- A $50 yearly deductible
- Continuous coverage prior to reaching $3,600 in out-of-pocket spending
- Coinsurance of 15% up to the out-of-pocket limit ($3,600)
- Co-payments of $2 and $5, respectively, beyond the out-of-pocket limit.

Q. An applicant for extra help shows the State's customer service representative a drug discount card and asks if the card is "still good". Does this card mean the applicant has qualified for extra help?
A. No, this is a Medicare-Approved Drug Discount Card. The discount card is another provision of the MMA and it provides a discount on prescription drugs. The discount card does not automatically entitle the card holder to extra help. The discount card cannot be used in conjunction with the extra help and will be phased out by May 15, 2006. The card holder may have a credit (known as Transitional Assistance) of up to $600 associated with the discount card. If the card holder doesn't know if they have this credit, they may ask their pharmacist to verify it for them. Medicare beneficiaries may apply for the discount card up until December 31, 2005 and use the card until May 15, 2006 or until they join a Medicare prescription drug plan, whichever is earlier. If they have a credit, they may wish to consider using this up before they enroll in a prescription drug plan.

Q. Will beneficiaries in the U.S. Territories be eligible for extra help?
A. While Medicare beneficiaries in the Territories are eligible for the Medicare Prescription Drug Program (Part D), they are not eligible for the extra help. However, they will have access to help with their prescription drug costs through their Territory.

Q. What is the difference in the extra help available to people who have Medicare and full Medicaid and beneficiaries who are eligible for MSP?
A. The benefits are the same except for copayments: individuals with income below 100% of the FPL have a lower copay than those whose income is between 100% and 135% of the Federal Poverty Level.

Q. Will a person lose their extra help if, during the year, they lose their status as automatically qualifying for the extra help?
A. The beneficiary will not lose the help during calendar year 2006. The change would be effective January 1, 2007.

Q. What constitutes "creditable coverage"?
A. Creditable coverage is prescription drug coverage through an insurer that is at least as good as the benefit available through a Medicare prescription drug plan. This may be coverage through an employer, former employer, or union. Entities providing prescription drug coverage are required to notify their members of whether their coverage is creditable or not. Medicaid is not creditable coverage.

Q. What effect does a Medicaid penalty have on eligibility for the extra help?
A. Eligibility for the extra help is not affected by a Medicaid penalty for disposal of an asset for less than fair market value.

Q. Will the extra help "work" if the beneficiary does not choose a prescription drug plan?
A. No, enrollment in a prescription drug plan may occur before or after application for the extra help, but it is important to remember that the extra help provides no benefit if the beneficiary is not enrolled in a prescription drug plan. Most Medicare beneficiaries must actively enroll in a prescription drug plan. The exceptions are:

- Beneficiaries who are already enrolled in a Medicare Health Plan with Prescription Drug Coverage (MA-PD).
- Persons with Medicare and full Medicaid will be enrolled automatically in a PDP, with an effective date of January 1, 2006, if they have not enrolled in a Part D plan by December 31, 2005. This ensures that these individuals do not lose drug coverage on January 1, 2006, when Medicaid coverage ends.
- Other persons who automatically qualify for extra help (persons eligible for SSI-cash only, QMB, SLMB, and QI, but not full Medicaid) will get enrollment into a PDP facilitated if they have not chosen a plan by May 15, 2006. Their enrollment would be effective on June 1, 2006. Beneficiaries who qualify automatically for extra help may change plans if they do not wish to remain in the plan chosen for them.
- Beneficiaries who apply for the extra help on their own and who are found eligible but who do not enroll in a PDP by May 15, 2006 will be enrolled into a plan with an effective date of June 1, 2006. These beneficiaries will have an opportunity to change plans if they wish.

Q. How will Medicare Prescription Drug Coverage work for Medicare beneficiaries who are children?
A. Beneficiaries who are eligible for Medicare and Medicaid and who are under 21 years of age have prescription drug benefits guaranteed under the Early & Periodic Screening, Diagnosis & Treatment Program (EPSDT). To the extent that the child's prescription drugs are not covered by their Medicare prescription drug plan, the State Medicaid program must provide drug coverage. Federal financial participation (FFP) is available for this activity.

Q. When should a person who is pending spenddown for Medicaid apply for the extra help?
A. If the beneficiary is already an MSP recipient, he or she will automatically have qualified for the extra help. If he or she is not an MSP recipient, he or she must apply for the extra help and may do so at any time. There is no need for the beneficiary to apply for the extra help when he or she meets the spenddown requirements because he or she will automatically qualify for the extra help based on receipt of Medicaid.

Q. How many people are eligible for the extra help?
A. CMS estimates that there are about 14.4 million people with Medicare who will be eligible for the extra help in the first year of the Medicare prescription drug program. The 14.4 million people are about a third of the estimated 43 million Medicare beneficiaries in 2006.

Q. What counts as income and resources?
A. The extra help has special income rules, based on but not identical to the rules for the Supplemental Security Income (SSI) program; whereas the rules for counting resources are, for the most part, the same as the standard SSI resource rules. The main difference is that most non-liquid resources will not be counted when determining eligibility for the extra help, whereas many such non-liquid resources would be counted under SSI. The income of the applicant and that of a spouse living in the same household will be counted and compared to a Federal poverty level standard applicable to the size of the family, which includes the applicant, their spouse, and dependent family members who live with them. The resources of the applicant and the spouse, if any, will be counted and compared to the resource threshold, and generally include liquid resources that can be readily converted to cash within 20 days, such as checking and savings accounts, and real estate that is not the applicant's primary residence.

Q. Do I have to sell my car or my farm/ranch to qualify for the extra help?
A. No. Vehicles and any farm or ranch land that is adjacent to your primary residence are not counted as resources.

Q. Do I have to cash in my life insurance policies to qualify for the extra help?
A. No, we will not require you to cash in your policies. However, if the policies have a total face value (i.e., death benefit) of $1,500 or more, the cash value of the policies (i.e., the amount you would receive if you turned them in today) counts towards the resource limit.

Q. What will standard Medicare prescription drug coverage look like for someone who qualifies for extra help?
A. People with Medicare and income below 135% of the Federal poverty level[1] and resources[2] of $7,500 for an individual or $12,000 for a couple will pay no premium[3] or deductible and nominal copayments of up to $2 for generics and preferred multiple source drugs and $5 for other drugs. Once their copayments plus the amount Medicare pays as the extra help reach $3,600, they will pay nothing for their prescriptions. For people with Medicare, full Medicaid benefits, and income less than 100% of poverty, they will have co-payments of up to $1 for generics and preferred multiple source drugs and up to $3 for other drugs. Again, once their copayments plus the amount Medicare pays as the extra help reach $3,600, they will pay nothing for their prescriptions. People with Medicare and full Medicaid benefits and who reside in an institution pay no premiums, no deductibles, no coinsurance, and no copayments.

People with Medicare and income below 150% of the Federal poverty level[4] and resources[5] up to $11,500 for an individual or $23,000 for a couple will only pay a $50 deductible, cost-sharing up

[1] In 2005, 135% of the Federal poverty level is $12,919 for individuals and $17,320 for couples. Someone may qualify with higher income if s/he is working or living in a larger household.
[2] These resource standards apply to individuals and couples who have burial funds set aside for burial expenses. If no funds are set aside for burial expenses, the resource standards are $6,000/individual and $9,000/couple.
[3] The beneficiary's premium is subsidized up to the low-income premium subsidy amount as defined in 42 CFR §423.780(b).
[4] In 2005, 150% of the Federal poverty level is $14,355 for individuals and $19,245 for couples. Someone may qualify with higher income if s/he is working or living in a larger household.

to 15% coinsurance, and a sliding-scale premium based on income. Once their copayments plus the amount Medicare pays as the extra help reach $3,600, s/he will have nominal co-payments of up to $2 or $5 per prescription.

Q. How does a person know if he/she qualifies for the extra help?
A. SSA will conduct a comprehensive, national outreach campaign to encourage potentially eligible people with Medicare to apply for the extra help. Outreach strategies include direct mailings, thousands of community events, and partnering with stakeholders such as States and community-based organizations. SSA will mail applications to potentially eligible people with Medicare in May through August of 2005, and begin processing applications July 1, 2005. SSA will send the person a determination once the application is processed, and will call individuals if there are questions about their application.

In separate mailings that will begin in May 2005, Medicare will notify certain groups who automatically qualify for extra help for the 2006 calendar year that they do not need to apply. These groups are people with Medicare who have full Medicaid benefits, people with Medicare who receive Supplemental Security Income benefits (but not Medicaid), and people with Medicare for whom their States pay their Medicare premiums and cost sharing (Medicare Saving Program). Anyone who believes that he or she may qualify for the extra help is encouraged to apply, and can do so by calling the Social Security Administration at 1-800-772-1213, by visiting www.socialsecurity.gov on the web or a State Medicaid office.

Q. An individual has prescription drug coverage from an employer/union plan. Should s/he apply for the extra help?
A. Even if they have employer/union coverage, individuals with limited income and resources may qualify for extra help. Individuals with employer/union coverage should talk with their plan or benefits administrator to find out how their employer/union coverage will work under Medicare prescription drug coverage in 2006. If this individual qualifies for extra help, s/he should also contact his or her State's Health Insurance Assistance Program (SHIP). Customer service representatives at 1-800-MEDICARE (1-800-633-4227) can provide the SHIP number for the individual's home state. A SHIP counselor can provide personalized assistance to help the individual decide whether it is better to keep the employer or union drug coverage or get Medicare prescription drug coverage.

Q. How and where does someone apply for the extra help?
A. An application for extra help may be filed with either SSA or a State's Medicaid program office. We are strongly encouraging States to use the SSA application and to assist applicants in filing their applications with SSA. States may assist individuals who present themselves at State offices in completing the SSA application, with the State sending the completed applications to SSA for processing.

If an individual requests a State application and a State eligibility determination, then the individual must follow the State's eligibility process, including the State's process for appeals and redeterminations associated with State eligibility determinations.

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[5] These resource standards apply to individuals and couples who have burial funds set aside for burial expenses. If no funds are set aside for burial expenses, the resource standards are $10,000/individual and $20,000/couple.

Q. Does it make a difference if a person goes to SSA or the State to apply for the extra help?
A. No. The rules for determining eligibility for the extra help are based on national standards that both SSA and the State will use. We strongly encourage people to use SSA's simplified application that relies on automated data matches for verification of income and certain liquid resources, minimizing both paperwork burden and cost.

Q. Do individuals need to apply for the extra help in person?
A. No. Individuals do not need go to SSA field offices or State offices to apply. They may apply by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or they may mail their completed applications to the Social Security Administration Wilkes-Barre Data Operations Center or complete an online application at www.socialsecurity.gov starting July 1.

Q. How will the State or SSA decide if a person qualifies for the extra help?
A. For a person applying for the extra help, the type of income to be counted is similar, but not identical to the rules of the Supplemental Security Income program. Generally the income of the applicant and that of any spouse who resides with the applicant will be counted. Once counted, income will be compared to a Federal poverty level standard applicable to size of the applicant's family to determine eligibility. Family size includes the applicant, the spouse residing with the applicant, if any, and the number of individuals who are related to the applicant, who are living in the same household, and who are dependent on the applicant, or their spouse, for at least one-half of their financial support. Resources that will be counted generally include liquid resources that can be readily converted to cash within 20 days (e.g., checking and savings accounts) and real estate that is not the applicant's primary residence. The resources of the applicant and the spouse, if living with the applicant, will be counted to determine if the applicant meets the resource threshold to be eligible.

Q. Who can help someone apply for the extra help?
A. There are other people who can fill out the application for someone to see if s/he qualifies for the extra help. These individuals are called personal representatives. A personal representative can be any of the following:

- The person who acts on someone's behalf if s/he is incapacitated or can't make decisions for himself/herself.
- Anyone someone chooses to act as his/her representative (such as a spouse, a child, or a caregiver).
- The representative payee whom the Social Security Administration selects to act on someone's behalf or a person authorized under State law to represent him/her.

Q. What is the earliest date someone with Medicare can apply for the extra help?
A. We are working with States and SSA on an outreach strategy to encourage individuals potentially eligible for extra help to apply as early as possible, starting in May 2005. SSA will mail applications to potentially eligible people starting in May 2005. We encourage people to pre-qualify for the extra help before enrolling in a prescription drug plan, so they will know ahead of time whether or not they are eligible for extra assistance with their Medicare

prescription drug plan costs. People can visit www.socialsecurity.gov or www.medicare.gov on the web to learn whether or not they may qualify for the extra help before they apply.

Q. Are applications for the extra help available online?
A. Yes. SSA will make their application available on their website at www.socialsecurity.gov starting on July 1, 2005. The application can be filed from this website. We encourage States, community groups, and family members to help people complete the application available on the website.

Q. How often does a person need to be redetermined eligible for the extra help?
A. If an individual applies for extra help with either SSA or the State in 2005, his or her initial eligibility determination remains in effect for all of 2006. If an individual applies for the first time in 2006, his or her initial eligibility determination remains in effect for a period not to exceed one year. After the initial determination, SSA and the State will set their respective re-determination timeframes, with the State basing its timeframes on its Medicaid rules. If an individual automatically qualifies for extra help because s/he has full Medicaid benefits, gets help paying Medicare premiums from the State, or gets Supplemental Security Income (SSI), then his or her eligibility remains in effect for calendar year. In August of each year starting in 2006, CMS will verify that an individual still automatically qualifies for extra help for the subsequent calendar year.

Q. If someone is found ineligible for extra help but later in the year loses a spouse or their income or resources go down, can s/he reapply?
A. Yes. However, remember that individuals must be enrolled in a Medicare prescription drug plan to get extra help.

Q. If a person moves out of state, does s/he have to reapply for the extra help?
A. A person will remain eligible for the remainder of the year that began with their month of application for extra help. If the person filed with SSA, then s/he needs to tell SSA his or her new address, but doesn't need to reapply. If the person filed with the State, then s/he needs to file with the new State or with SSA before the end of the year in order for coverage to continue into the next year.

Q. If a person applies for extra help with the State and is found ineligible, can s/he then apply for the extra help with SSA or vice versa?
A. Individuals have the ability to file with either SSA or the State, or both. However, SSA and States will be using the same set of national rules. Rather than filing a new application with SSA, the individual is encouraged to file an appeal with the State if s/he believes the decision was incorrect.

Q. How long will it take a State to process an application for the extra help?
A. In general, we expect States to process applications within time periods that are at least consistent with the processing of State Medicaid applications. CMS regulations currently require States to make eligibility determinations within 45 days except in unusual circumstances.

Q. If a person applied for extra help and was found eligible for premium assistance, a reduced deductible and cost-sharing, but later in the year becomes eligible for full Medicaid benefits, will s/he then automatically get the premium assistance, $0 deductible and $0-$5 co-payments?

A. Yes. The State determining Medicaid eligibility will transmit this information to Medicare for the beneficiary to receive the assistance for which they qualify. CMS will notify the person that he or she is automatically eligible for the premium assistance, $0 deductible and $0-$5 co-payments.

Q. How will a State or the Social Security Administration know if someone with Medicare is already eligible for extra help?
A. We are working with SSA and the States to facilitate information sharing, so that CMS will know whether an individual is found eligible by SSA or a State.

Q. How will a prescription drug plan know if their member qualifies for extra help?
A. CMS will inform plans offering Medicare prescription drug coverage which of their enrollees are eligible for the extra help, and the amount of assistance for which they qualify.

Q. If someone enrolls in a Medicare prescription drug plan and later qualifies for the extra help, does the plan have to repay him or her for any cost-sharing incurred?
A. Yes. The plan will reimburse the enrollee back to the effective date of the extra help, which is the first of the month in which the application is filed. If a person is determined to be eligible for extra help retroactively, the plan will also have to reimburse the enrollee back to the start date of their eligibility.

Q. How will the States and SSA know if someone automatically qualifies for extra help and does not need to apply?
A. CMS will notify the person with Medicare as well as SSA and the State of his or her auutomatic eligibility for extra help.

Q. If someone is determined eligible for extra help, does s/he also qualify for other Federal assistance?
A. No, not automatically. As part of making an eligibility determination, states are required to screen applicants for Medicaid and the Medicare Savings Programs and offer enrollment if the individual meets that state's Medicare Savings Programs requirements. CMS will work with SSA on a process to provide eligibility determinations to states for the purposes of identifying individuals who apply at SSA and who may also qualify for Medicare Savings Programs under the state's Medicaid program.

Q. If someone gets extra help, does that mean Medicare will enroll him or her in a prescription drug plan?
A. We strongly encourage everyone with Medicare to look at information about the Medicare prescription drug plans in their area starting in fall of 2005 and enroll in one that meets their needs. However,

- If a person with Medicare and full Medicaid benefits doesn't enroll in a Medicare prescription drug plan by December 31, 2005, then Medicare will enroll him or her in a plan automatically to ensure continuous drug coverage. If the person finds that there is a different Medicare prescription drug plan that betters meets his or her needs, s/he can change to this plan at any time.
- If a person with Medicare also gets Supplemental Security Income (but no Medicaid), or gets help paying Medicare premiums, deductibles or co-insurance from the State (Medicare Savings Programs) but doesn't enroll by May 15, 2006, then Medicare will enroll him or her in a plan unless s/he asks not to be enrolled. If the person finds that there is a different Medicare prescription drug plan that betters meets his or her needs, s/he can change to this plan.
- If someone with Medicare applies and is found eligible for this extra help and doesn't enroll by May 15, 2006, then Medicare will enroll him or her in a plan unless s/he asks not to be enrolled. If the person finds that there is a different Medicare prescription drug plan that betters meets his or her needs, s/he can change to this plan.

Q. Can people with Medicare apply for the extra help if they currently have a Medicare-Approved Drug Discount Card, even if they have remaining credit on their card?
A. Yes. If they qualified for the $600 credit for their Medicare-approved drug discount card, they may also qualify for extra help with their Medicare prescription drug plan costs. If they get Supplemental Security Income or their State helps pay for their Medicare premium and cost-sharing, then they automatically qualify for this help and do not need to apply. If they don't belong to either one of these groups, then they will need to apply for the extra help. If they get an application in the mail from the Social Security Administration in the summer of 2005, they should fill it out and send it in as soon as possible. If they don't get an application in the mail by September 2005, they should call 1-800-MEDICARE (1-800-633-4227) and ask for one. People who have a Medicare-approved drug discount card can continue to use their card and any remaining transitional assistance until May 15, 2006, or until they join a Medicare prescription drug plan, whichever comes first.

Q. Is it too late to apply for the $600 credit on the Medicare-Approved Drug Discount Card Program? Does applying for the credit on the Medicare-approved drug discount card affect an application for extra help with Medicare prescription drug plan costs?
A. Someone can apply for a Medicare-approved drug discount and pro-rated $600 credit up until December 31, 2005. An application for the credit will not affect an application for the extra help with Medicare prescription drug plan costs. The amount of the credit will depend on when someone applies for a Medicare-approved drug discount card. If someone applies after April 1, 2005, the amount of the credit decreases.

Q. What if people do not join a Medicare prescription drug plan? Can they still get extra help with their prescription drug costs?
A. People must enroll in a Medicare prescription drug plan in order for the extra help to apply to their prescription drug costs, such as premiums and cost sharing.

Q. Are States required to take applications for the extra help from residents of other States?

A. No. However, States are permitted to assist people with Medicare in filling out and filing the SSA application for extra help. If someone who does not reside in the State asks for a State eligibility determination, then the State should direct him or her to apply in his or her State of residence.

APPENDIX II – CALCULATION TABLES

Subsidy Calculation for One Person

Countable Resources in $	≤135% FPL	> 135% to ≤140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150% FPL	≥ 150%
≤ $6,000	A	C	D	E	F
> $6,000 to ≤ $10,000	B	C	D	E	F
> $10,000	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in $	≤ 135% FPL	> 135% to ≤ 140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150%	≥ 150%
≤ $9,000	A	C	D	E	F
> $9,000 to ≤ $20,000	B	C	D	E	F
> $20,000	F	F	F	F	F

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Pre-Catastrophic Co-pay per Prescription	Coverage Gap? Y/N	Catastrophic Co-pay per Prescription
A	100%*	$0	$2/$5	N	$0
B	100%*	$50	15%	N	$2/$5
C	75%	$50	15%	N	$2/$5
D	50%	$50	15%	N	$2/$5
E	25%	$50	15%	N	$2/$5
F (No subsidy)	0%	$250	25%	Y	@5%

*Percentage is the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region.

APPENDIX III - ACRONYMS

BWE- blind work expenses.

CMS- the Centers for Medicare & Medicaid Services, formerly known as Health Care Financing Administration (HFCA).

EPSDT- Early & Periodic Screening, Diagnosis & Treatment Program.

FBDE- full-benefit dual eligible.

FFP- Federal financial participation.

IRWE- Impairment-related work expenses.

LIS- Low-Income Subsidy.

MA-PD- a Medicare Advantage plan which offers both prescription drug and health care coverage.

MMA-the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

MSP- Medicare Saving Programs (QMB, SLMB, and QI).

PDP- a private prescription drug plan that offers drug-only coverage.

POMS-Program Operations Manual System

SSA- the Social Security Administration.

SSI- Supplemental Security Income.

WBDOC- Wilkes-Barre Data Operations Center.

APPENDIX IV – PRECEDENCE OF LIS DECISIONS

Scenario	SSA	State	Outcome
1	Denial	Approval	Approval is official determination. Beneficiary may appeal either decision.
2	Approval	Denial	Approval is official determination. Beneficiary may appeal either decision.
3	Denial	Denial	The beneficiary may appeal either decision. If both are appealed and overturned, see scenarios 4 and 5.
4	Approval (Different Month)	Approval (Different Month)	If the subsidy effective dates are in different months, the decision with the earlier effective date is the official determination. The second decision is void.
5	Approval (Same Month)	Approval (Same Month)	If the subsidy effective dates are the same, the SSA decision is the official determination. The beneficiary may appeal either decision.

APPENDIX V

	2005 POVERTY LEVEL GUIDELINES				
	ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.				
Income Guidelines as Published in the Federal Register on February 18, 2005					
		ANNUAL GUIDELINES			

FAMILY	PERCENT OF POVERTY				
SIZE	100%	135%	140%	145%	150%
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1	9,570.00	12,919.50	13,398.00	13,876.50	14,355.00
2	12,830.00	17,320.50	17,962.00	18,603.50	19,245.00
3	16,090.00	21,721.50	22,526.00	23,330.50	24,135.00
4	19,350.00	26,122.50	27,090.00	28,057.50	29,025.00
5	22,610.00	30,523.50	31,654.00	32,784.50	33,915.00
6	25,870.00	34,924.50	36,218.00	37,511.50	38,805.00
7	29,130.00	39,325.50	40,782.00	42,238.50	43,695.00
8	32,390.00	43,726.50	45,346.00	46,965.50	48,585.00
For family units of more than 8 members, add $3,260 for each additional member.					
		MONTHLY GUIDELINES			

FAMILY	PERCENT OF POVERTY				
SIZE	100%	135%	140%	145%	150%
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1	797.50	1,076.63	1,116.50	1,156.38	1,196.25
2	1,069.17	1,443.38	1,496.83	1,550.29	1,603.75
3	1,340.83	1,810.13	1,877.17	1,944.21	2,011.25
4	1,612.50	2,176.88	2,257.50	2,338.13	2,418.75
5	1,884.17	2,543.63	2,637.83	2,732.04	2,826.25
6	2,155.83	2,910.38	3,018.17	3,125.96	3,233.75
7	2,427.50	3,277.13	3,398.50	3,519.88	3,641.25
8	2,699.17	3,643.88	3,778.83	3,913.79	4,048.75

APPENDIX VI

2005 POVERTY LEVEL GUIDELINES

HAWAII

Income Guidelines as Published in the Federal Register on February 18, 2005

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	11,010.00	13,212.00	14,643.30	14,863.50	16,515.00	19,267.50	20,368.50	22,020.00	27,525.00
2	14,760.00	17,712.00	19,630.80	19,926.00	22,140.00	25,830.00	27,306.00	29,520.00	36,900.00
3	18,510.00	22,212.00	24,618.30	24,988.50	27,765.00	32,392.50	34,243.50	37,020.00	46,275.00
4	22,260.00	26,712.00	29,605.80	30,051.00	33,390.00	38,955.00	41,181.00	44,520.00	55,650.00
5	26,010.00	31,212.00	34,593.30	35,113.50	39,015.00	45,517.50	48,118.50	52,020.00	65,025.00
6	29,760.00	35,712.00	39,580.80	40,176.00	44,640.00	52,080.00	55,056.00	59,520.00	74,400.00
7	33,510.00	40,212.00	44,568.30	45,238.50	50,265.00	58,642.50	61,993.50	67,020.00	83,775.00
8	37,260.00	44,712.00	49,555.80	50,301.00	55,890.00	65,205.00	68,931.00	74,520.00	93,150.00

For family units of more than 8 members, add $3,750 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	917.50	1,101.00	1,220.28	1,238.63	1,376.25	1,605.63	1,697.38	1,835.00	2,293.75
2	1,230.00	1,476.00	1,635.90	1,660.50	1,845.00	2,152.50	2,275.50	2,460.00	3,075.00
3	1,542.50	1,851.00	2,051.53	2,082.38	2,313.75	2,699.38	2,853.63	3,085.00	3,856.25
4	1,855.00	2,226.00	2,467.15	2,504.25	2,782.50	3,246.25	3,431.75	3,710.00	4,637.50
5	2,167.50	2,601.00	2,882.78	2,926.13	3,251.25	3,793.13	4,009.88	4,335.00	5,418.75
6	2,480.00	2,976.00	3,298.40	3,348.00	3,720.00	4,340.00	4,588.00	4,960.00	6,200.00
7	2,792.50	3,351.00	3,714.03	3,769.88	4,188.75	4,886.88	5,166.13	5,585.00	6,981.25
8	3,105.00	3,726.00	4,129.65	4,191.75	4,657.50	5,433.75	5,744.25	6,210.00	7,762.50

APPENDIX VII

2005 POVERTY LEVEL GUIDELINES

ALASKA

Income Guidelines as Published in the Federal Register on February 18, 2005

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	11,950.00	16,132.50	16,730.00	17,327.50	17,925.00
2	16,030.00	21,640.50	22,442.00	23,243.50	24,045.00
3	20,110.00	27,148.50	28,154.00	29,159.50	30,165.00
4	24,190.00	32,656.50	33,866.00	35,075.50	36,285.00
5	28,270.00	38,164.50	39,578.00	40,991.50	42,405.00
6	32,350.00	43,672.50	45,290.00	46,907.50	48,525.00
7	36,430.00	49,180.50	51,002.00	52,823.50	54,645.00
8	40,510.00	54,688.50	56,714.00	58,739.50	60,765.00

For family units of more than 8 members, add $4,080 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	995.83	1,344.38	1,394.17	1,443.96	1,493.75
2	1,335.83	1,803.38	1,870.17	1,936.96	2,003.75
3	1,675.83	2,262.38	2,346.17	2,429.96	2,513.75
4	2,015.83	2,721.38	2,822.17	2,922.96	3,023.75
5	2,355.83	3,180.38	3,298.17	3,415.96	3,533.75
6	2,695.83	3,639.38	3,774.17	3,908.96	4,043.75
7	3,035.83	4,098.38	4,250.17	4,401.96	4,553.75
8	3,375.83	4,557.38	4,726.17	4,894.96	5,063.75

APPENDIX VIII – LEADS DATA

What data do states receive on those on whom SSA has made a low-income subsidy (LIS) determination?

Background: States need data on LIS determinations for coordination (to be sure someone who applies at state has not already been determined LIS eligible by SSA). States are also strongly encouraged to screen beneficiaries who have applied for the subsidy at SSA for MSP eligibility (QMB, SLMB, QI).

Data elements States will receive:

- Subsidy Approved (Y/N)
- Subsidy Approval/Disapproval Date
- LIS effective date (first day of month of application)
- Resources over or under LIS limit
- Income used for determination (individual/couple)
- Income as Percent of Federal poverty level
- Denial reason (no Medicare, not in USA, failure to cooperate, resources too high, income too high)
- Mailing address

This data will not contain dollar amounts of income or resources.